Complete Summary

GUIDELINE TITLE

Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department.

BIBLIOGRAPHIC SOURCE(S)

Lukens TW, Wolf SJ, Edlow JA, Shahabuddin S, Allen MH, Currier GW, Jagoda AS, ACEP Clinical Policies Subcommittee (Writing Committee) on Critical Issues [trunc]. Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. Ann Emerg Med 2006 Jan;47(1):79-99. [65 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references drugs for which important revised regulatory and/or warning information has been released.

On April 12, 2005, the U.S. Food and Drug Administration (FDA) issued a public health advisory to alert health care providers, patients, and patient caregivers to new safety information concerning an unapproved, "off-label" use of certain antipsychotic drugs approved for the treatment of schizophrenia and mania. FDA has determined that the treatment of behavioral disorders in elderly patients with dementia with atypical (second generation) antipsychotic medications is associated with increased mortality. Clinical studies of these drugs in this population have shown a higher death rate associated with their use compared to patients receiving a placebo. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Behavioral emergencies from acute psychotic disturbances, manic episodes, major depression, bipolar disorder, and substance abuse

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Screening
Treatment

CLINICAL SPECIALTY

Emergency Medicine
Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To provide evidence-based recommendations for the medical assessment and management of adult patients who present to the emergency department (ED) with psychiatric symptoms
- To address the following critical questions:
    - What testing is necessary in order to determine medical stability in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and psychiatric symptoms?
    - Do the results of a urine drug screen for drugs of abuse affect management in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and a psychiatric complaint?
    - Does an elevated alcohol level preclude the initiation of a psychiatric evaluation in alert, cooperative patients with normal vital signs and a noncontributory history and physical examination?
    - What is the most effective pharmacologic treatment for the acutely agitated patient in the ED?

TARGET POPULATION

Adult patients presenting to the emergency department with psychiatric symptoms

This guideline, with the exception of question IV (see the "Major Recommendations" field), is not intended for patients with delirium or abnormal vital signs, altered cognition, or abnormal physical examination. Pediatric patients are also excluded.

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Routine laboratory evaluation in emergency department psychiatric patients with normal vital signs and a noncontributory history and physical examination.
2. Urine toxicologic screens for drugs of abuse in the evaluation of alert, cooperative psychiatric patients with normal vital signs and a noncontributory history and physical examination in the emergency department.
3. Blood alcohol testing in patients being evaluated for psychiatric conditions in the emergency department.

Treatment

1. Pharmacologic treatment of acute agitation in the emergency department setting with benzodiazepines and/or antipsychotics.

MAJOR OUTCOMES CONSIDERED

- Utility and effectiveness of routine laboratory testing, urine screens for drugs of abuse, and blood alcohol testing in the assessment of emergency department patients with psychiatric complaints
- Efficacy of various pharmacologic treatments of the agitated patient in the emergency department

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

MEDLINE searches for articles published between January 1980 and January 2005 were performed using a combination of key words and their variations, including "psychiatry," "medical clearance," "agitation," "toxicologic screens," "drugs of abuse," "alcohol testing," and names of individual drugs. Searches were limited to English-language sources. Additional articles were reviewed from the bibliography

of articles cited. Subcommittee members also supplied articles from their own knowledge base.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Strength of evidence Class I--Interventional studies including clinical trials, observational studies including prospective cohort studies, aggregate studies including meta-analyses of randomized clinical trials only

Strength of evidence Class II--Observational studies including retrospective cohort studies, case-controlled studies, aggregate studies including other meta-analyses

Strength of evidence Class III--Descriptive cross-sectional studies, observational reports including case series and case reports, consensus studies including published panel consensus by acknowledged groups of experts

Strength of evidence Class I and II articles were then rated on elements subcommittee members believed were most important in creating a quality work. Class I and II articles with significant flaws or design bias were downgraded on the basis of a set formula (see Appendix C in the original guideline document). Strength of evidence Class III articles were downgraded if they demonstrated significant flaws or bias. Articles downgraded below strength of evidence Class III were given an "X" rating and were not used in formulating recommendations in this policy.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

This clinical policy was created after careful review and critical analysis of the medical literature.

All publications were graded by at least 2 of the subcommittee members into 1 of 3 categories of strength of evidence. Some articles were downgraded on the basis of a standardized formula that considers the size of study population, methodology, validity of conclusions, and potential sources of bias (see Appendix B of the original guideline document).

During the review process, all articles were given a baseline "strength of evidence" by the subcommittee members according to the criteria outlined in "Rating Scheme for the Strength of the Evidence."

An Evidentiary Table was constructed and is included in the original guideline document.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This policy is a product of the American College of Emergency Physicians (ACEP) clinical policy development process and is based on the existing literature; where literature was not available, consensus of emergency and psychiatric physicians was used.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendations regarding patient management were made according to the following criteria:

Strength of Recommendations

Level A recommendations. Generally accepted principles for patient management that reflect a high degree of clinical certainty (i.e., based on "strength of evidence Class I" or overwhelming evidence from "strength of evidence Class II" studies that directly address all the issues)

Level B recommendations. Recommendations for patient management that may identify a particular strategy or range of management strategies that reflect moderate clinical certainty (i.e., based on "strength of evidence Class II" studies that directly address the issue, decision analysis that directly addresses the issue, or strong consensus of "strength of evidence Class III" studies)

Level C recommendations. Other strategies for patient management based on preliminary, inconclusive, or conflicting evidence, or, in the absence of any published literature, based on panel consensus

There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. Factors such as heterogeneity of results, uncertainty about effect magnitude and consequences, strength of prior beliefs, and publication bias, among others, might lead to such a downgrading of recommendations.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Expert review comments were received from individual emergency physicians and psychiatrists and from members of the American Association for Emergency Psychiatry, American Association of Community Psychiatrists, American Psychiatric Association, and Emergency Nurses Association. Their responses were used to further refine and enhance this policy.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the strength of evidence (Class I-III) and strength of recommendations (Level A-C) are repeated at the end of the "Major Recommendations" field.

1. What testing is necessary in order to determine medical stability in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and psychiatric symptoms?

   Level A recommendations. None specified.

   Level B recommendations. In adult emergency department (ED) patients with primary psychiatric complaints, diagnostic evaluation should be directed by the history and physical examination. Routine laboratory testing of all patients is of very low yield and need not be performed as part of the ED assessment.

   Level C recommendations. None specified.

2. Do the results of a urine drug screen for drugs of abuse affect management in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and a psychiatric complaint?

   Level A recommendations. None specified.

   Level B recommendations. None specified.

   Level C recommendations.

   1. Routine urine toxicologic screens for drugs of abuse in alert, awake, cooperative patients do not affect ED management and need not be performed as part of the ED assessment.

2. Urine toxicologic screens for drugs of abuse obtained in the ED for the use of the receiving psychiatric facility or service should not delay patient evaluation or transfer.

3. Does an elevated alcohol level preclude the initiation of a psychiatric evaluation in alert, cooperative patients with normal vital signs and a noncontributory history and physical examination?

   Level A recommendations. None specified.

   Level B recommendations. None specified.

   Level C recommendations.

   1. The patient's cognitive abilities, rather than a specific blood alcohol level, should be the basis on which clinicians begin the psychiatric assessment.
   2. Consider using a period of observation to determine if psychiatric symptoms resolve as the episode of intoxication resolves.

4. What is the most effective pharmacologic treatment for the acutely agitated patient in the ED?

   Level A recommendations. None specified.

   Level B recommendations.

   1. Use a benzodiazepine (lorazepam or midazolam) or a conventional antipsychotic (droperidol* or haloperidol) as effective monotherapy for the initial drug treatment of the acutely agitated undifferentiated patient in the ED.
   2. If rapid sedation is required, consider droperidol* instead of haloperidol.
   3. Use an antipsychotic (typical or atypical) as effective monotherapy for both management of agitation and initial drug therapy for the patient with known psychiatric illness for which antipsychotics are indicated.
   4. Use a combination of an oral benzodiazepine (lorazepam) and an oral antipsychotic (risperidone) for agitated but cooperative patients.

   Level C recommendations. The combination of a parenteral benzodiazepine and haloperidol may produce more rapid sedation than monotherapy in the acutely agitated psychiatric patient in the ED.

   *Refer to the discussion of droperidol in the original guideline document.

Definitions:

Strength of Evidence

Strength of evidence Class I--Interventional studies including clinical trials, observational studies including prospective cohort studies, aggregate studies including meta-analyses of randomized clinical trials only

Strength of evidence Class II--Observational studies including retrospective cohort studies, case-controlled studies, aggregate studies including other meta-analyses

Strength of evidence Class III--Descriptive cross-sectional studies, observational reports including case series and case reports, consensus studies including published panel consensus by acknowledged groups of experts

Strength of Recommendations

Level A recommendations. Generally accepted principles for patient management that reflect a high degree of clinical certainty (i.e., based on "strength of evidence Class I" or overwhelming evidence from "strength of evidence Class II" studies that directly address all the issues)

Level B recommendations. Recommendations for patient management that may identify a particular strategy or range of management strategies that reflect moderate clinical certainty (i.e., based on "strength of evidence Class II" studies that directly address the issue, decision analysis that directly addresses the issue, or strong consensus of "strength of evidence Class III" studies)

Level C recommendations. Other strategies for patient management based on preliminary, inconclusive, or conflicting evidence, or, in the absence of any published literature, based on panel consensus

There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. Factors such as heterogeneity of results, uncertainty about effect magnitude and consequences, strength of prior beliefs, and publication bias, among others, might lead to such a downgrading of recommendations.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate evaluation and management of patients with psychiatric symptoms

POTENTIAL HARMS

Adverse Effects of Medications

- Caution needs to be taken in caring for agitated patients with medical illness so that any reversible causes are identified and treated. In addition, agitation may be a result of drug ingestions or poisonings with anticholinergic or sympathomimetic agents. In this scenario, the antipsychotics, both conventional and atypical, and the medications used to manage extrapyramidal symptoms can potentially exacerbate agitation because of their anticholinergic side effects.
- In 2001, the US Food and Drug Administration (FDA) issued a black box warning about droperidol's potential for dysrhythmias, making its subsequent use problematic. However, large patient series have appeared attesting to its safety. Some authors have reviewed the existing reports of droperidol toxicity, including all of the material submitted to the FDA on which the ruling was based, and concluded that although droperidol can be associated with prolongation of the QT interval, there is not convincing evidence that the drug causes severe cardiac events.
- Atypical and conventional antipsychotics can cause QTc interval prolongation and dystonia.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Recommendations offered in this policy are not intended to represent the only diagnostic and management options that the emergency physician should consider. The American College of Emergency Physicians (ACEP) clearly recognizes the importance of the individual physician's judgment. Rather, this guideline defines for the physician those strategies for which medical literature exists to provide support for answers to the crucial questions addressed in this policy.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Lukens TW, Wolf SJ, Edlow JA, Shahabuddin S, Allen MH, Currier GW, Jagoda AS, ACEP Clinical Policies Subcommittee (Writing Committee) on Critical Issues [trunc]. Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. Ann Emerg Med 2006 Jan;47(1):79-99. [65 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Jan

GUIDELINE DEVELOPER(S)

American College of Emergency Physicians - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Emergency Physicians

GUIDELINE COMMITTEE

Clinical Policies Subcommittee on Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department

ACEP Clinical Policies Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

ENDORSER(S)

American Association for Emergency Psychiatry - Medical Specialty Society

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American College of Emergency Physicians Web site.

Print copies: Available from the American College of Emergency Physicians, ACEP Customer Service Department, P.O. Box 619911, Dallas, TX 75261-9911, or call toll free: (800) 798-1822, touch 6.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on February 13, 2006. The information was verified by the guideline developer on April 6, 2006.

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